# Common Elements in Guidelines for Prescribing Opioids for Chronic Pain

The use of opioids for treating chronic pain has been increasing.[1] In 2010, an estimated 20% of patients presenting to physician offices in the United States with pain symptoms or diagnoses were prescribed opioids.[2] Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse or overdose from these powerful drugs.

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control, along with the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC), reviewed eight guidelines to identify common recommendations (see accompanying Table). Guidelines on chronic pain that had been issued on or before January 2013 and developed by professional societies, states, or Federal agencies for general practitioners were considered. Guidelines for specific conditions or subpopulations were excluded, as were those specific to pain specialists.

Guidelines varied by development methodology (systematic review, expert opinion) and conflict of interest management (disclosure, voting recusal) (see Table). According to the Institute of Medicine, trustworthy clinical practice guidelines appropriately manage conflict of interest, use systematic reviews of the evidence to inform recommendations, and rate the strength of the evidence and recommendations.[3]

The following guidelines were reviewed:

- American Pain Society/American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain (2009)[4]
- Utah State Clinical Guidelines on Prescribing Opioids for Treatment of Pain (2009)[5]
- Veterans Affairs/Department of Defense Management of Opioid Therapy for Chronic Pain (2010)[6]
- Washington State Agency Medical Directors Group Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain (2010)[7]
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain (2011)[8]
- American College of Occupational and Environmental Medicine Guidelines for the Chronic Use of Opioids (2011)[9]
- New York City Department of Health and Mental Hygiene Opioid Prescribing Guidelines (2011)[10]
- American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Noncancer Pain (2012)[11]

Recommendations from each of these guidelines were reviewed, extracted, and coded into categories of provider actions associated with pre-treatment, initial opioid treatment, follow-up, and discontinuation phases. This process resulted in a common set of provider actions and associated recommendations that can be seen in the table.

Common recommendation elements found in all the guidelines include:

- Conducting a physical exam, pain history, past medical history, and family/social history
- Conducting urine drug testing, when appropriate
- Considering all treatment options, weighing benefits and risks of opioid therapy, and using opioids when alternative treatments are ineffective
- Starting patients on the lowest effective dose
- Implementing pain treatment agreements
- Monitoring pain and treatment progress with documentation; using greater vigilance at high doses
- Using safe and effective methods for discontinuing opioids (e.g., tapering, making appropriate referrals to medication-assisted treatment, substance use specialists, or other services)

An additional recommendation element appearing in several guidelines that will become more feasible as states enhance their data systems includes:

- Using data from Prescription Drug Monitoring Programs (PDMPs) to identify past and present opioid prescriptions at initial assessment and during the monitoring phase

It is useful to identify common recommendation elements across guidelines to help inform others who may be considering developing their own guidelines.

In addition, rigorous, evidence-based recommendations can be incorporated into clinical decision support, such as within the electronic health record, to make it easier for health providers to follow guidelines.

| Provider Action | Guideline Recommendations | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | APS/AAPM | Utah | VA/DoD | WA State | Canadian | ACOEM | NYC | ASIPP |
| **PRE-TREATMENT** | | | | | | | | |
| **Pain history** | Conduct history; diagnostic tests to evaluate pain condition | Assess prior treatment of pain | Evaluate prior pain treatment, fear, interference with function | Assess function, pain status, current opioid therapy | Assess history of pain condition; previous opioid trials | Conduct detailed pain history | Conduct detailed history that includes medications, onset, location, quality, duration, and intensity | Conduct detailed pain history; previous medication trials; pain intensity and functional impairment |
| **Past medical history** | Conduct history; substance abuse/misuse/addiction testing | Assess medical and mental health conditions, medications, substance addiction or dependence | Assess medical and psychiatric history; substance use; suicide | Screen for depression and anxiety; substance use | History of general medical condition, psychosocial history, psychiatric status, substance use history | Comprehensive medical history; screening for addiction | Comprehensive medical history | Comprehensive medical history |
| **Family History/Social History** | Conduct psychosocial assessment and family history | Assess social history | Concurrent interview of family members; comprehensive social history | Not addressed | Comprehensive family/social history | Comprehensive family/social history | Comprehensive family/social history | Comprehensive family/social history |
| **Pregnancy** | Counsel women of childbearing potential; Minimal/no use during pregnancy; Anticipate and manage risks during pregnancy | Not addressed | Estimate risk of opioid therapy in pregnancy | Not addressed | Prescribe lowest effective dose; discontinue if possible | Not addressed | Not addressed | Not addressed |
| **Prescription Drug Monitoring Program - Initial assessment of past use** | Not addressed | Check PDMP | Not addressed | Not addressed | Check PDMP | Not addressed | Check PDMP | Check PDMP |
| **Physical Exam** | Conduct physical exam | Assess pain severity, functional status, quality of life | Comprehensive physical examination | Comprehensive baseline assessment | Comprehensive physical examination | Conduct physical exam | Conduct physical exam | Comprehensive physical examination |

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| **Laboratory - Urine Drug Screening initial assessment** | Not addressed | Perform before initiating long term opioids | Obtain in all patients prior to initiation of opioids. | Conduct baseline on all current prescription opioid users and for those considering chronic opioid therapy | Conduct baseline measure of risk | Conduct at baseline | Consider for all patients | Must be used to establish a baseline measure of risk |
| **Opioid Indication** | Consider alternatives to opioids and trial when benefits are likely to outweigh risks and no alternative therapy likely to pose favorable benefit/harm balance | Consider all options, including non-pharmaceutical treatment; opioids considered only when other therapies not beneficial | Inadequate response to non-drug or non-opioid modalities, or when benefits outweigh risks of opioid therapy | Consider when other physical, behavioral, and non-opioid measures have failed and no contraindication to use (e.g., substance abuse) | Use in mild to moderate or severe pain. | Anatomical/physiologic abnormalities; other non-opioids, adjuvants, and alternative pain control modalities inadequate; no contraindications | Consider when potential benefits are likely to outweigh potential harm; when other approaches to analgesia are ineffective | Establish medical necessity based on moderate/severe pain, organic problem, failure to respond to non-controlled substance, adjuvants, physical therapy/exercise, and other interventions |
| **INITIAL OPIOID TREATMENT** | | | | | | | | |
| **Drug choice** | Initial therapeutic trial (weeks to months); Selection, dosing, titration individualized based on health status, opioid exposure, goals, and harms | Short term trial; start with short acting opioids | Start with trial; shared decision-making process with patient; education and knowledge when selecting a specific opioid | Trial of short acting opioids before long acting | Select opioid based on clinical profile and individual circumstances; Codeine or Tramadol suggested as first-line | Start short-acting opioids; avoid high-dose opioids; meperidine, propoxyphene, combination agonists, and mixed agonists/antagonists not recommended | Short acting opioids for acute pain; avoid long acting opioids; do not consider opioids first line for chronic non-cancer pain | Start with short acting opioids; long acting opioids recommended only in specific circumstances |
| **Methadone** | Initiate and titrate cautiously by clinicians familiar with use/risks | Prescribed by clinicians familiar with its risks and use | Initiate and titrate cautiously by clinicians familiar with use/risks or consult with experienced clinician | Special care should be taken | Use methadone under select circumstances | Not addressed | Additional caution needed | Use after failure of other opioids; use by clinicians with specific training in the risks and uses |

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| **Starting dosage** | Start at low dose and titrate slowly | Start at low dose and titrate slowly | Start at low dose | Use lowest effective dose | Start at low dosage, increase gradually | Start with low dose | Start with the lowest possible effective dose | Start at low dosage, increase gradually |
| **Duration of initial treatment** | Several weeks to months | Short term trial | Not addressed | Not addressed | Not addressed | Not to exceed 4 weeks; in rare situations may extend by 2 weeks | Not addressed | 8 to 12 weeks |
| **Co-prescribing** | Not addressed | Close attention to benzodiazepines/other sedatives | Not addressed | Do not combine with sedative-hypnotics, benzodiazepines or barbiturates unless indicated | Exercise caution; consider tapering benzodiazepine or opioid | Evaluate based on individual patient needs | Avoid benzodiazepines or other depressants | Do not combine with sedative hypnotics, benzodiazepines, or barbiturates unless indicated |
| **Documentation** | Informed consent; Written management plan | Written treatment plan; Informed consent; written education material to patient, family, caregiver | Written agreement; informed consent; document patient preferences; provide written educational materials to patient, family | Written treatment agreement | Informed consent; goal setting; oral or written treatment agreements | Written opioid agreement; goal setting; expectations; risks/benefits | Written treatment agreement; goal setting; expectations; risks/benefits | Informed consent; Written management plan |
| **FOLLOW-UP VISITS** | | | | | | | | |
| **Treatment progress** | Monitor pain intensity, level of functioning, progress toward goals, adverse events, adherence; assess aberrant drug-related behaviors, substance use, psychological issues | Regular visits with evaluation of progress; assess analgesia, activity, adverse effects, and aberrant behavior | Evaluate pain intensity at each visit; evaluate function; assess patient satisfaction | Assess function and pain status, adverse effects, comorbidities, drug combinations or other substance abuse at each visit | Assess pain intensity and function at each visit; monitor adverse effects, medical complications, compliance, and risks | Evaluate functional activity, participation in social activities, | Regular follow-up visits; assess pain level, adverse events, functional improvement, and compliance | Regular follow up visits; assess compliance, adverse events, aberrant behaviors, improvement |
| **High-dose opioids** | >200mg/day; more frequent and intense monitoring for high dose | >120-200 MME/day; increase clinical vigilance | Refer or consult if the dose is > 200 MME/day | >120 MME/day consultation from expert | >200 MME/day; reassess or monitor | MME not specified; frequent follow-up; documentation of improved function | >100 MME/day, reassess pain status or consider other approaches | >91 MME/day; consider pain management consultation |

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| **Co-prescribing** | Not addressed | Not addressed | Careful monitoring | Do not combine with sedative-hypnotics, benzodiazepines or barbiturates unless indicated | Exercise caution; consider tapering benzodiazepine or opioid | Use Tramadol cautiously in patients taking tricyclic, SSRI, or SNRI anti-depressants | Avoid prescribing opioids with benzodiazepines or other depressants | Do not combine opioids with sedative hypnotics, benzodiazepines, or barbiturates unless indicated |
| **Past controlled prescription drug use** | Routine behavior assessment; Check PDMP | Check PDMP regularly | Not addressed | Not addressed | Check PDMP | Not addressed | Routine behavior assessment; Check PDMP | Continued PDMP checks |
| **Laboratory - Urine Drug Screening Monitoring** | If high risk, periodic urine drug screens; if not high risk, consider periodic screens | Randomly selected visits and when aberrant behavior is suspected | Conduct randomly at follow-up visits, increase frequency based on risk level | Random testing based on risk category | Consider risk for opioid misuse and addiction, aberrant drug-related behaviors, and availability of UDS during follow-up | Random screening; at least once and up to 4 times a year and at termination | Repeat randomly, based on risk level (yearly for low risk to every 3 months for high risk) | Randomly repeat at frequency determined by risk |
| **OPIOID DISCONTINUATION** | | | | | | | | |
| **Rationale documentation** | Taper/wean patients engaging in repeated aberrant drug-related behaviors or abuse/diversion; no progress; intolerable adverse effects | Document nonadherence to the treatment plan; discontinue if goals are not met, if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated | Document any evidence of misuse, abuse, or addiction | No improvement; adverse effects; aberrant behaviors | Document all aspects of opioid trial; discontinue if pain remains unresponsive | Failure to improve; aberrant behaviors | Document all aspects of opioid trial; discontinue if signs of opioid misuse | Document all aspects of opioid trial; consider taper or discontinue if no improvement, adverse effects or aberrant behavior |
| **Tapering plan** | Slow 10% reduction/week to rapid 25%-50% reduction/few days | 10% reduction/week over 6 to 8 weeks | Taper by 20%-50% per week; faster or slower tapering may be warranted | 10% reduction/week over 6 to 8 weeks | Variable; 10% of the total daily dose every day, or 10% of the total daily dose every 1–2 weeks | Not addressed | Reduction of 10% each day, 20% every 3 to 5 days, or 25% each week | Decrease by 10% of the original dose per week |

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| **Referral for Medication Assisted Treatment or other substance abuse treatment services as appropriate** | Make treatment available and arrange continued follow-up | Consider consultation for complex cases or referral to a pain management, mental health or substance use specialist | Refer to SUD specialty when behavior suggests addiction; refer to behavioral health specialty for psychological problems | If signs of alcohol or substance abuse refer to an addiction specialist | When needed, consult pain management or addiction specialists; referral for treatment intervention | Referral for mental health, substance use specialist, pain management specialist | Explain the option of buprenorphine and refer to an addiction specialist, buprenorphine provider, or methadone maintenance treatment program | Assess for abuse/addiction and refer for addiction treatment and pain management as appropriate |
| **GUIDELINE DEVELOPMENT METHODS** | | | | | | | | |
| **Evidence review, grading, and decision making** | Systematic review; Grading of Recommendations Assessment, Development and Evaluation; majority approval | Review of previous guidelines; consensus approval | Systematic review; expert opinion; US Preventive Services Task Force evidence grading | Expert opinion | Systematic review; expert opinion; consensus approval; Canadian Task Force on Preventive Healthcare grading | Expert opinion | Not addressed | Systematic review; expert opinion; consensus approval; US Preventive Services Task Force grading |
| **Conflicts of Interest** | Disclosed; recused from voting | Disclosed | Not addressed | Not addressed | Disclosed | Not addressed | Not addressed | Disclosed |

**Guidelines**

APS/AAPM = American Pain Society/American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain

Utah = Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

VA/Dod = Veteran's Administration/Department of Defense Management of Opioid Therapy for Chronic Pain

WA State = Washington State Agency Medical Directors Group Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain

Canadian = Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain

ACOEM = American College of Occupational and Environmental Medicine Guidelines for the Chronic Use of Opioids

NYC = New York City Department of Health and Mental Hygiene Opioid Prescribing Guidelines

ASIPP = American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Noncancer Pain

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